MAP-9 (Rev. 12/95)			COMMONWE	ALTH OF I	KENTUCKY					
			CABINET FOR	R HUMAN R	RESOURCES				•	
1		55	KENTUCKY	MEDICAID	PROGRAM					
1. Me	ed. Assist. I.D. No.		OR AUTHORIZAT	ION FOR F	HEALTH-SERVI				- 	
1. 1016	eu. Assist. I.D. No.	2. Recipient	Last Name:		ļ	First Name); :		4. M.I.	
 	Ten Digits									
5a: F	Provider Number	6a Providor	Name, Address,	and Dhane	Alumba a					
Ja. 1	T T T T T T T T T	da. Flovidei	Name, Address,	and Phone	Number		[7		Recipient	
	Eight Digits							Residen	ice:	
5b B	Provider Number	Namo Addroon	e, Address, and Phone Number				 			
So. Flowder Warne			Name, Address, a	s, Address, and Phone Number				8. Date of Delivery		
Eight Digits								(if already delivered)		
a Dri	imary Diagnosis:									
3. 111	inary Diagnosis.						11. Date of Birth			
10 S	econdary Diagnosis:									
0	blughosis.						\ \ \	M DD	YYYY	
Signature of Provider:				Date: Ca			order for you to receive			
				Date.			payment, the recipient must be eligible on			
							the date of service.			
				<u>·</u>			Check The Medicaid Card.			
12.	ne Procedure/ Supply Description		14.	15. Units of	16. Usual and		edicaid	id 18. Approved		
Line			Procedure				Action			
No.			Supply Code	Service	Customar		pproved		4mount*	
01					Charges	D=Dis	approved	<u></u>		
01.]					
02.				 		 				
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<u>}3.</u>										
04.										
05.										
06.										
10 H	CB and Model Waiver Prov	idara antar Ar	nerovimeta Total M	lanthir Cha		<u> </u>				
19. 11	CD and woder waiver Prov	nders enter Ap	proximate rotativ	ioniniy Cha	rge:					
			DO NOT WRIT	- DEL OW	\$					
20 0	For David		DO NOT WRIT	E BELOW	I HIS LINE			-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
20. R	eason For Denial:									
21 0	ther Comments:								·····	
21. 0	arer comments.									
22. Prior Authorization Number: 23. Approval Dates: 24. Type of Service Authorized:										
			40 DME				7 (411)01120	u.		
		From:					VAIVER			
	Mailroom Use		45EPS				PECIAL S	SERVICE		
				46HON				EALTH		
			Through:							
			1					_H.C.B & A.D.C		
			72DEN				•			
*Not used by H.C.B Waiver/Model Waiver				OTH						
Signat										
Signat	ure of Medicaid/Prior Autho	nization Kespi	esentative:							
					Date:					
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